Complete Summary

GUIDELINE TITLE

Depression in older adults.

BIBLIOGRAPHIC SOURCE(S)

Kurlowicz LH. Depression in older adults. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 185-206. [33 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Depression

GUIDELINE CATEGORY

Evaluation
Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Geriatrics
Internal Medicine
Nursing
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Pharmacists
Physician Assistants
Physicians
Social Workers
Utilization Management

GUIDELINE OBJECTIVE(S)

- To present an overview of depression in older patients, with emphasis on age-related assessment considerations, clinical decision-making, and nursing intervention strategies for elders with depression
- To provide a standard of practice protocol for use by nurses in practice settings
- To discuss the consequences of late-life depression
- To identify nursing strategies for older adults with depression
- To discuss the major risk factors for late-life depression
- To identify the core competencies of a systematic nursing assessment for depression with older adults

TARGET POPULATION

Hospitalized older adults

INTERVENTIONS AND PRACTICES CONSIDERED

Risk Assessment/Prognosis

1. Individualized depression assessment and interview
    - Review medical/social history
    - Assess for presence of risk factors
    - Ask direct questions regarding symptoms of depression, suicidal ideation, psychosis, recent losses or crises
    - Review medications
    - Assess cognitive dysfunction and functional disability
2. Standardized assessment tool (e.g., Geriatric Depression Scale-Short Form)

Treatment/Management

1. Refer/consult mental health services as indicated
2. Incorporate psychosocial and behavioral nursing interventions into individualized care plan, including:
    - Safety precautions
    - Promotion of nutrition, elimination, sleep/rest patterns, physical comfort, and pain control
    - Relaxation strategies
    - Daily activity schedule
3. Refer to physical, occupational, and recreation therapies to encourage mobilization

4. Identify, mobilize, or designate a support person such as family, a confidant, friends, volunteers or other hospital resources, church member, support groups, patient or peer visitors, and appropriate clergy for spiritual support
5. Maximize autonomy, personal control, self-efficacy, and decision making about clinical care, daily schedules, and personal routines
    - Graded task assignment
    - Participation in regular, predictable pleasant activities
    - Pleasant events inventory
    - Music therapy
    - Pleasant reminiscences
      Photographs, old magazines, scrapbooks
6. Provide emotional support through:
    - Empathetic, supportive listening
    - Encouraging patients to express their feelings in a focused manner on issues such as grief or role transition
    - Supporting adaptive coping strategies
    - Identifying and reinforcing strengths and capabilities
    - Maintaining privacy and respect
    - Instilling hope
7. Monitor
    - Therapeutic response to medication
    - Potential side effects of medication
8. Provide patient/family education

MAJOR OUTCOMES CONSIDERED

- Prevalence of depression among older adults
- Symptomatic presentation
- Adverse effects of depression (physical, psychosocial, and behavioral functioning)
- Mortality/suicide associated with depression among older adults
- Percentage of older adults receiving services for primary psychiatric disorders, including depression
- Validity of Geriatric Depression Scale-Short Form
- Effectiveness of treatment (e.g., pharmacotherapy, psychosocial therapies)
- Effectiveness of nursing interventions
- Recurrence rate

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline was the database used.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Informal Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Assessment Parameters

- Identify risk factors/high risk groups:
    - Current alcohol /substance use disorder
    - Specific comorbid conditions (dementia, stroke, cancer, arthritis, hip fracture, myocardial infarction, chronic obstructive pulmonary disease, and Parkinson's disease)
    - Functional disability (especially new functional loss)
    - Widows/widowers
    - Caregivers
    - Social isolation/absence of social support
- Assess all at-risk groups using a standardized depression screening tool and documentation score. The Geriatric Depression Scale-Short Form (GDS-SF) is recommended because it takes approximately 5 minutes to administer, has been validated and extensively used with medically ill older adults, and includes few somatic items that may be confounded with physical illness.
- Perform a focused depression assessment on all at-risk groups and document results. Note the number of symptoms; onset; frequency/patterns; duration (especially 2 weeks); changes in normal mood, behavior and functioning.
    - Depressive symptoms:
        - Depressed or irritable mood, frequent crying
        - Loss of interest, pleasure (in family, friends, hobbies, sex)
        - Weight loss or gain (especially loss)
        - Sleep disturbance (especially insomnia)
        - Fatigue/loss of energy
        - Psychomotor slowing/agitation
        - Diminished concentration
        - Feelings of worthlessness/guilt
        - Suicidal thoughts or attempts; hopelessness
    - Psychosis (i.e., delusional/paranoid thoughts, hallucinations)
    - History of depression; current substance abuse (especially alcohol); previous coping style
    - Recent losses or crises (e.g., death of spouse, friend, pet; retirement; anniversary dates; move to another residence or nursing home); changes in physical health status, relationships, or roles
    - In elderly persons, frequent somatic (physical) complaints may actually represent an underlying depression
- Obtain/review medical history and physical/neurological examination.
- Assess for depressogenic medications (e.g., steroids, narcotics, sedatives/hypnotics, benzodiazepines, antihypertensives, histamine-2 antagonists, beta-blockers, antipsychotics, immunosuppressives, cytotoxic agents).
- Assess for related systematic and metabolic processes (e.g., infection, anemia, hypothyroidism or hyperthyroidism, hyponatremia, hypercalcemia, hypoglycemia, congestive heart failure, and kidney failure).
- Assess for cognitive dysfunction.
- Assess level of functional disability.

Care Parameters

- For severe depression (GDS score 11 or greater, 5 to 9 depressive symptoms [must include depressed mood or loss of pleasure] plus other positive

responses on individualized assessment [especially suicidal thoughts or psychosis and comorbid substance abuse]), refer for psychiatric evaluation. Treatment options may include medication or cognitive-behavioral, interpersonal, or brief psychodynamic psychotherapy/counseling (individual, group, family), hospitalization, or electroconvulsive therapy.

- For less severe depression (GDS score 6 to 10, fewer than five depressive symptoms, plus other positive responses on individualized assessment), refer to mental health services for psychotherapy/counseling (see above types), especially for specific issues identified in individualized assessment and to determine whether medication therapy may be warranted. Consider resources such as psychiatric liaison nurses, geropsychiatric advanced practice nurses, social workers, psychologists, and other community and institution-specific mental health services. If suicidal thoughts, psychosis, or comorbid substance abuse are present, a referral for a comprehensive psychiatric evaluation should always be made.
- For all levels of depression, develop an individualized plan integrating the following nursing interventions:
    - Institute safety precautions for suicide risk as per institutional policy (in outpatient settings, ensure continuous surveillance of the patient while obtaining an emergency psychiatric evaluation and disposition).
    - Remove or control etiologic agents.
        - Avoid/remove/change depressogenic medications.
        - Correct/treat metabolic/systemic disturbances.
    - Monitor and promote nutrition, elimination, sleep/rest patterns, and physical comfort (especially pain control).
    - Enhance physical function (i.e., structure regular exercise/activity; refer to physical, occupational, recreational therapies); develop a daily activity schedule.
    - Enhance social support (i.e., identify/mobilize a support person(s) [e.g., family, confidant, friends, hospital resources, support groups, patient visitors]); ascertain need for spiritual support and contact appropriate clergy.
    - Maximize autonomy/personal control/self-efficacy (e.g., include patient in active participation in making daily schedules and setting short-term goals).
    - Identify and reinforce strengths and capabilities.
    - Structure and encourage daily participation in relaxation therapies, pleasant activities (conduct a pleasant activity inventory), and music therapy.
    - Monitor and document responses to medication and other therapies; readminister depression screening tool.
    - Provide practical assistance; assist with problem-solving.
    - Provide emotional support (i.e., empathic, supportive listening; encourage expression of feelings and hope instillation), support adaptive coping, and encourage pleasant reminiscences.
    - Provide information about the physical illness and treatment(s) and about depression (i.e., that depression is common, treatable, and not the person's fault).
    - Educate about the importance of adherence to prescribed treatment regimen for depression (especially medication) to prevent recurrence; educate about specific antidepressant side effects due to personal inadequacies.

- Ensure mental health community linkup; consider psychiatric, nursing home care intervention.

Follow-up to Monitor Condition

- Continue to track prevalence and documentation of depression in at-risk groups.
- Show evidence of transfer of information to postdischarge mental health service delivery system.
- Educate caregivers to continue assessment processes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Patient Will Demonstrate:

- Personal safety
- Evaluation by psychiatric services for severe depression
- Reduction of symptoms indicative of depression (e.g., reduction in the Geriatric Depression Scale (GDS) score and resolution of suicidal thoughts or psychosis
- Improved daily functioning

Health Care Provider Will Demonstrate:

- Early recognition of patient at risk, referral, and interventions for depression
- Improved documentation of outcomes

Institution Will Demonstrate:

- Increased number of patients identified with depression
- No increase in the number of in-hospital suicide attempts
- Increased referrals to mental health services
- Increased referrals to psychiatric nursing home care services
- Improved staff education on depression recognition, assessment, and interventions

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

The John A. Hartford Foundation Institute for Geriatric Nursing - Academic Institution

GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Author: Lenore H. Kurlowicz, PhD, RN, CS and NICHE Faculty; Assistant Professor of Geropsychiatric Nursing, School of Nursing, University of Pennsylvania

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Copies of the book Geriatric Nursing Protocols for Best Practice, 2nd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 26, 2004.

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